COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

"The Rising Cost of Health Care: How Are Employers and Employees Responding?"

JUNE 18, 2002

Presentation by
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Commissioner

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Tab #1

Biography of S. Catherine Longley

S. Catherine Longley is the Commissioner of the Maine Department of Professional and Financial Regulation. She was appointed to the post by Maine's Independent Governor, Angus S. King, Jr. in February, 1995. As Commissioner she acts as the chief administrative officer of the Department which regulates banks, credit unions, HMO's, insurance companies, investment advisors, broker-dealers, mortgage companies and licenses numerous professions and occupational trades.

A member of Governor King's cabinet, Commissioner Longley is responsible for developing executive policy in the areas of financial services, health insurance, workers' compensation and professional licensing. The Department's $15 million annual budget encompasses the Bureau of Banking, the Bureau of Insurance, the Office of Consumer Credit Regulation, the Office of Securities, thirty-six professional/occupational licensing boards, and six licensing boards affiliated with the Department. The Department employs approximately 200 people.

Catherine has played a leadership role on several task forces and commissions, including chairing the Governor's Economic Development Subcommittee on Financial Services, the Governor's Interstate Banking/Branching Advisory Committee and serving on the Prescription Drug Advisory Committee and the Productivity Realization Task Force. She is a graduate of the Leadership Maine Program (Epsilon) Class and the 1997 recipient of the Dirigo Award from the Maine Chamber and Business Alliance for achievements in public service. Ms. Longley currently serves as a director of the Maine Development Foundation and as a member of the Maine Health Care Performance Council.

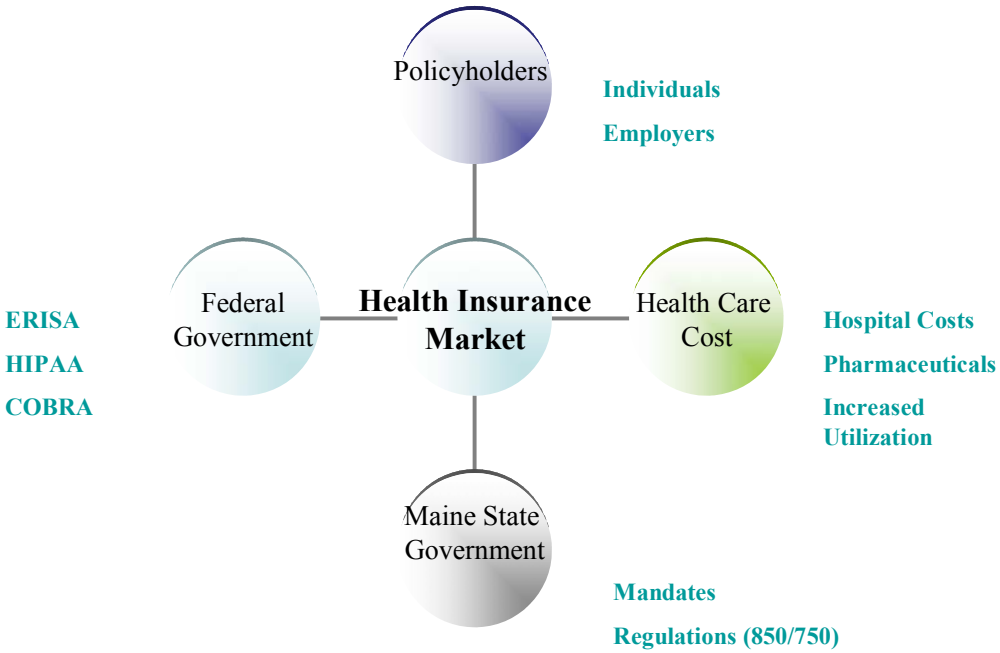
Prior to her appointment to Maine state government, Ms. Longley, who holds a J.D. degree cum laude from Suffolk University Law School and an A.B. degree in history from Bowdoin College, was a partner at the Portland, Maine law firm of Verrill & Dana, where she practiced corporate and public finance law. During her twelve years with Verrill & Dana, she also co-chaired the firm's corporate law department.

Tab #2

Characteristics of Maine's Health Insurance Market

Characteristics of Maine's Health Insurance Market

Market Pressures



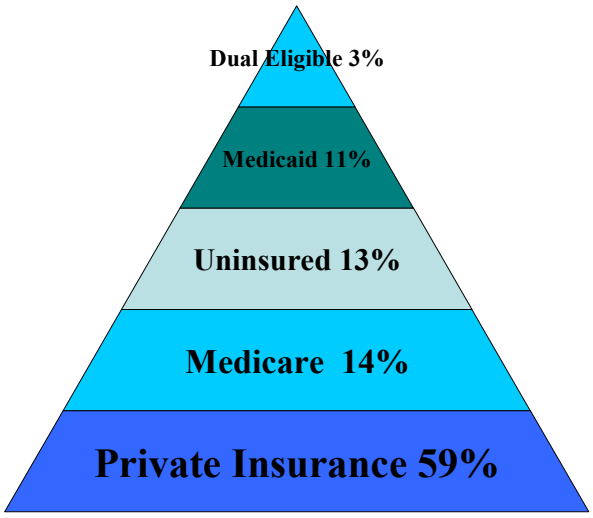
Health Care Costs in Maine

- In 1999, the citizens of Maine spent almost $5 billion dollars per year for personal health
- This is an average of $3,901 per person and represents nearly 14% of Maine's gross state product (Nationally, the 3rd highest percentage of GSP in 1998)[1]
- Between 1990—1998, Maine's health care costs increased at the fastest rate in the United States: ↑ 80.4% in Maine compared to 53.3% nationally[2]
- By 2010, the number is expected to be approximately $9 billion, with the largest increases coming in home health care and prescription drugs, and the smallest in hospital and physician services

[1] Source: US DHHS, CMS, State Health Expenditures

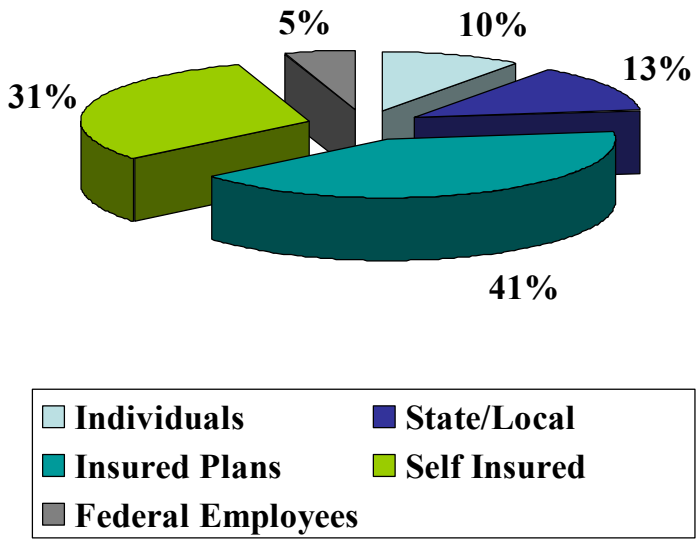
[2] Source: Morgan Quitno's Health Care State Rankings 2002

Health Care Cost Allocation
(by Percent of Maine Population)



Source: Final Report of the Year 2000 Blue Ribbon Commission (Nov 2000)

The 59% in Private Insurance is Fragmented Into this Breakdown



The 38% of the Market the Maine Bureau of Insurance Regulates:

The fully insured population is further segmented:

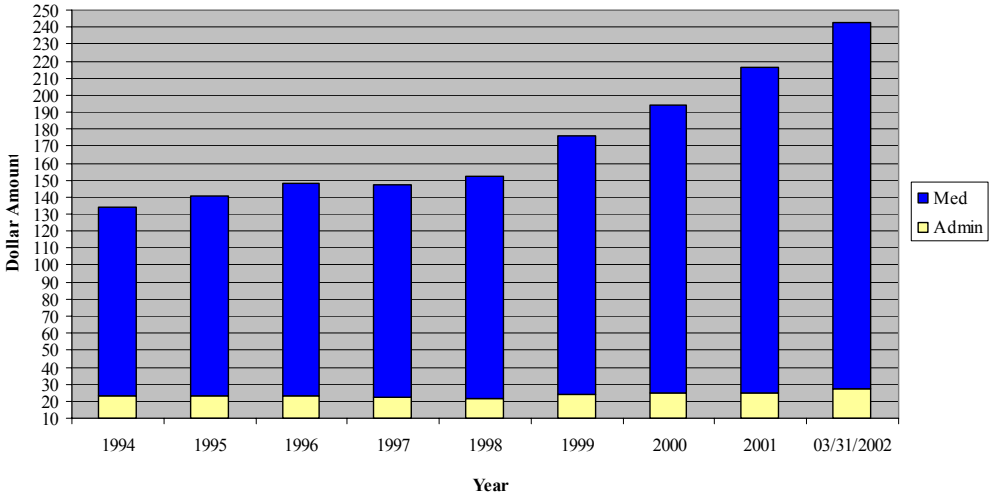
- Employer Sponsored
  - Large Group (51 & greater) (68% of market)[1]
  - Small Group (1-50) (26% of market) [1]
- Individual policies (6% of market) [1]
  - Health Insurance
  - Medicare Supplement

[1] Percentage of market is calculated from the 1999 premium written.

Characteristics of the Insurance Market:

- Double digit premium increases
- 20%-30% increase in pharmaceutical costs
- Hospital costs make up approximately 40% of medical costs
- Number of employees offered coverage over the last 10 years has declined
- Number of employees accepting coverage has declined
- Number of persons with individual health insurance coverage has decreased dramatically. This portion of market in "death spiral."

Medical and Administrative Expenses of Maine HMO's



Medical and Administrative Expenses Per Member Per Month are the total of all medical, hospital, and administrative expenditures for the Maine domestic HMO's as reported in their financial statements divided by the total member months as reported in their financial statements, except that HMO Maine's financial information is based on gross amounts (exclusive of quota share reinsurance).

Source: Maine Bureau of Insurance, 2002

Current Maine Health Insurance Rates for a Family of 4

Market	Plan[1]	Rate Range/Month[2]
Small Group	HMO	$947 - $1,394
Small Group	HMO Point-of-Service	$1,029 - $1,556
Small Group	PPO	$795 - $1,160
Small Group	Indemnity	$936 - $1,409
Individual	HMO	$1,905 - $2,307
Individual	Indemnity ($500 deductible)	$1,369
Individual	Indemnity ($5,000 deductible)	$ 433

[1] Plan Design Assumptions:

Small Group HMO plan assumes $20 office co-pay, $100 hospital co-pay, $10/$20/$30 drug co-pays (Generic/Formulary/Brand)
Small Group HMO Point-of-Service plan same as HMO plus out-of-network services are covered after a deductible and coinsurance
Small Group PPO In-Network assumes $250 deductible, 80/20 coinsurance, $750 out-of-pocket limit, Out-of-Network assumes $500 deductible, 60/40 coinsurance, $1,500 out-of-pocket limit
Small Group Indemnity assumes $250 deductible, 80/20 coinsurance, $750 out-of-pocket limit
Individual HMO assumes $10 office co-pay, $250 hospital co-pay, $10/$20 drug co-pays (Generic/Brand)
Individual Indemnity ($500 deductible) assumes 80/20 coinsurance, $700 out-of-pocket limit
Individual Indemnity ($5,000 deductible) assumes no coinsurance

[2] Rates shown are community rates for a two-adult family with children. Rates may vary 20% up or down based on age, industry, and geographic area.
Small group rates assume a ten-employee group. The range of rates shown is for insurers for which data is available. Other insurers may be outside this range.

Results for HMO Business & Blue Cross Business in Maine
1997 - 6/30/01

06/30/2001	
Pre-tax Income(Loss)	$ (10,598,130)
Provision for Fed Taxes	$ (3,297,183)
Net Income(Loss)	$ (7,300,947)
2000	
Pre-tax Income(Loss)	$ (32,460,634)
Provision for Fed Taxes	$ (5,650,867)
Net Income(Loss)	$ (26,809,767)
1999	
Pre-tax Income(Loss)	$ (64,914,531)
Provision for Fed Taxes	$ (2,968,906)
Net Income(Loss)	$ (61,945,625)
1998	
Pre-tax Income(Loss)	$ (33,587,917)
Provision for Fed Taxes	$ (7,226,448)
Net Income(Loss)	$ (26,361,469)
1997	
Pre-tax Income(Loss)	$ (54,887,205)
Provision for Fed Taxes	$ (1,078,579)
Net Income(Loss)	$ (53,808,626)
Grand Totals for 1997 - 6/30/01	
Pre-tax Income(Loss)	**$ (196,448,417)**
Provision for Fed Taxes	**$ (20,221,983)**
Net Income(Loss)	**$ (176,226,434)**

Tufts NE Net Loss numbers for 1997 - 1999 have been provided by Tufts Management. Pre-tax numbers are assumed to be the same as post-tax, and the Provision for Federal taxes is assumed to be 0.

Harvard numbers for 1997 - 1999 are estimated based on ME premiums compared to total premiums.

Harvard numbers for 2000 are based on estimates HPHC management has for Maine losses for 2000 (entire year).

Harvard numbers for 1/1/01 - 6/30/01 have been estimated.

It is highly likely that Harvard losses through 1999 in Maine are in excess of estimates used here.

Contributing Factors to Health Care Cost "Crisis"

- Aging population
- High level of chronic disease
- Lack of provider competition
- Disconnect between costs and consumer
- Rural demographics
- Unintended consequences of regulation; mandated benefits
- Medical errors
- High cost impacting access to care/insurance
- Cost shifting among public/private programs *i.e.*, Medicaid and Medicare
- Consumer expectations

Tab # 3

“How Your Health Insurance Dollar is Spent”

MAINE DEPARTMENT OF
Professional
& Financial
Regulation

How Your Health Insurance Dollar Is Spent

January 2002

Angus S. King, Jr.
Governor

S. Catherine Longley
Commissioner

Alessandro A. Iuppa
Superintendent

How Your Health Insurance Dollar Is Spent

In Maine, as in many other parts of the country, health insurance premiums are experiencing their biggest increases since the early 1990s. Health care expenses continue to grow faster than spending for other goods and services. Nationwide, average annual increases of 13% or more are projected for insurance plans over the next year.[1]

In 1999, health insurance bought by Maine employers cost an average of about $2,400 per year per employee, and an average of about $6,200 to cover both employees and their families.[2] These rates have since seen double-digit increases, with increases as high as 50% for some businesses . According to one national estimate, the health insurance cost for each employee will increase an average of $746 this year.[3] Maine can expect to see double-digit increases for at least several more years.

Who's affected?

Everyone's affected by increases in health care spending, but small businesses and individuals in Maine face particular challenges.

Small businesses - In 2001, small businesses across the country experienced higher increases in health insurance premiums than larger firms. This trend is predicted to continue into 2002.

Fewer than half of Maine businesses offer health insurance to their workers, but those that do provide coverage for almost 60% of Maine people.[4] Most Maine businesses are small. In national surveys, significant numbers of small employers say they may drop their health insurance if rates rise by 10% in the coming year.[5]

Nationally, of the employers that offer health insurance, fewer than half pay the full cost of that insurance.[6] The weakening economy has put more economic pressure on employers, so they are shifting more of the health care costs to their workers. Employees across the country will probably pay between $186 and $463 more annually for health insurance over the course of 2002 than they did in 2001.[7] Many workers refuse health insurance for themselves or their families because of the costs.

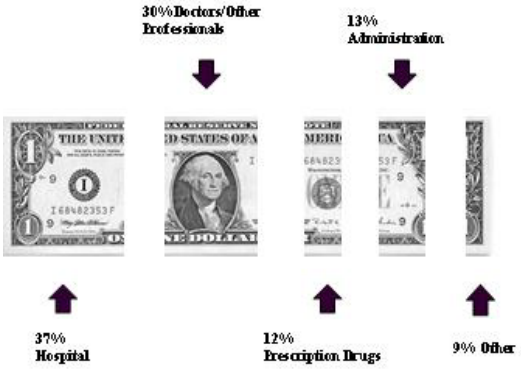
Individuals - Individuals who buy their own health insurance have an even tougher time maintaining coverage. Many healthy self-employed Mainers, or Mainers whose employers don't provide insurance, have dropped coverage because it is too expensive, leaving those with the greatest medical need in this market. The very small size of this market and the high medical needs of the people remaining in this market have resulted in significant premium increases since 1998.

Everyone faces greater out-of-pocket costs. In addition to paying a larger health insurance premium cost, people must pay greater copayments and deductibles, as well as higher costs for prescription drugs. In 1999, the average Mainer paid between $1,000 and $2,000 out-of-pocket for personal health care expenditures.[8]

Where does the money go?

Private health insurance rates are based on several costs, including those for hospitals, doctors and other health care professionals, and prescription drugs. The following graphic illustrates where healthcare dollars went in 1999.

How Maine Health Care Dollars Are Spent (1999)



Hospital care: 34%
Doctors/other professionals: 22%
Nursing home care: 11%
Prescription drugs: 10%
Administration: 8%
Other (including home health & durable medical equipment): 15%

Source: Year 2000 Blue Ribbon Commission on Health Care

Hospitals

In 1999, approximately 37¢ of every insurance dollar spent on medical costs in Maine paid for hospital costs.[9] In 2000, HMOs in Maine paid approximately 40% of their medical costs for in- and out-patient hospital services.[10] And in 2001, 10 hospital systems are among Maine's top 100 revenue-producing firms; two are in the top 10.[11] On a national level, increases in hospital

costs account for nearly half of the overall health care spending increase in the past year.[12] Reasons for these increases include: more bargaining power with insurers (especially in rural areas, where a hospital may be the only choice), labor shortages, and making up for shortfalls because Maine Care (Medicaid) and Medicare don't pay their full costs (more on this in "cost-shifting," on page 7).

Doctors, other health care professionals

In 1999, approximately 30¢ of every insurance dollar spent on medical costs in Maine paid for services provided by Maine doctors or other health care professionals.[13] Nationally, increases in spending for doctors and other professionals accounted for one-quarter of the overall increase in health care spending in the past year.[14] Specialty physician salaries in particular have jumped as a result of greater patient demand and the fact that residency training in the 1990s stressed primary care.[15]

Many doctors have joined with hospitals to create physician-hospital organizations. These organizations may be patients' only choice, especially in rural areas, so insurance companies are compelled to include them in their networks. This means these organizations have greater leverage in negotiating fees to participate in these networks.

Shortages among health care professionals – such as nurses and pharmacists – also lead to increased costs for medical services both in hospitals and through other health care providers.

- In Maine hospitals, nearly 10% of nursing positions are unfilled.[16]

- In hospitals across the country, 21% of pharmacist positions are unfilled.[17] In retail pharmacies across the country, the number of unfilled pharmacist positions rose to 7,000 in the year 2000 from 2,700 two years earlier.[18]

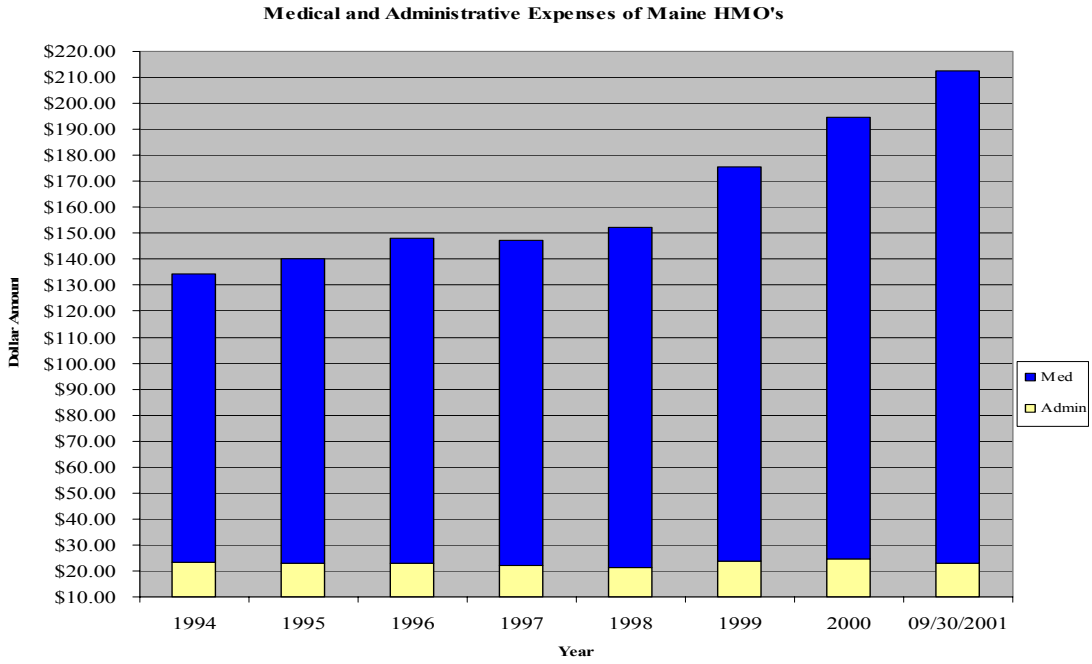
Because these professionals are scarce, attracting qualified individuals means offering signing bonuses or higher wages. Facilities may also be paying increased overtime to existing workers to maintain adequate staffing levels.

Prescription drugs

In 1999, approximately 12¢ of every insurance dollar spent in Maine on medical costs paid for prescription drugs.[19] Nationally, increases in spending for drugs made up more than one quarter of the overall increase in health care spending in the past year.[20] Drug spending could increase by 20% in the coming year.[21] This higher spending is due to three things: higher prices for existing drugs, changes in the types of drugs used (as newer and more expensive drugs replace older drugs), and – most importantly – more people using more drugs. Direct advertising to consumers on TV and in magazines has contributed to more people demanding the latest prescription drug.

Administrative costs

In 1999, approximately 13¢ of every insurance dollar spent in Maine on medical costs paid for insurers' administrative services.[22] As the chart on the following page shows, the administrative costs for Maine HMOs – which often have higher administrative costs than other insurers – are dropping as a percentage of their total costs.



Source: Maine Bureau of Insurance, 2001 Medical and Administrative Expenses Per Member Per Month are the total of all medical, hospital, and administrative expenditures for the Maine domestic HMO's as reported in their financial statements divided by the total member months as reported in their financial statements, except that HMO Maine's financial information is based on gross amounts (exclusive of quota share reinsurance).

Other cost pressures

Cost-shifting - Different people pay different prices for medical services, which may or may not reflect the costs of these services. For example, about one-third of Mainers receive health care coverage from Medicare and Maine Care (Medicaid).[23] However, Maine Care (Medicaid) and Medicare often pay health care providers less than the cost of the service. Maine hospital administrators say that Medicare underpays a total of $100 million per year.[24] These uncompensated costs are borne by Mainers who have health insurance or self fund their health care expenses.

Greater use of health care services - Elderly people tend to use more medical services than younger people, and Maine has the 16th highest percentage of residents age 65 or older in the country.[25] We'll soon have more people over 65 than under 18, a first in Maine's history.[26]

Mainers also tend to be less healthy than people in other states. Lifestyle choices account for a significant portion of health care problems in Maine, resulting in high usage of health care services.

- Nearly one-quarter of the population of Maine smokes.[27] In 1993, over $343 million were spent on medical costs related to smoking.[28]

- Over half the population in Maine is considered overweight or obese.[29] If coronary bypass surgery and angioplasty – which are often connected with obesity – were reduced by 20%, the health care system would save $38.3 million a year.[30]

Insurance underwriting cycle - In the mid-1990s, insurance companies offered premiums lower than their expected cost in order to attract more enrollees. After years of financial losses (over $176 million in Maine since 1997),[31] most are trying to play "catch-up."

More expensive medical technologies - Many new medical technologies have resulted in improvements in health care. However, these new technologies frequently cost much more than the tools they replace. Demand for the newest treatments increases overall health care spending.

Regulation - State and federal mandates, aimed at protecting insured people, can also drive up costs. In Maine, mandated benefits are estimated to have increased insurance rates for businesses with more than 20 people by up to 8%, and for businesses with 20 or fewer people or for individuals by up to 4%.[32] Maine's regulations that require health plans to provide access to a hospital within one hour's drive have resulted in insurance companies having to keep most hospitals in their networks, giving hospitals the power to negotiate tough financial terms.

What you can do

You can do several things to slow down the rate at which health care spending is increasing:

- Become an educated health care consumer and learn the real cost of medical services, as well as the best ways to get the care you need to stay healthy.
    - If you're choosing a doctor, look for one who encourages you to ask questions and explains things clearly. You may want to ask family, friends, coworkers, or even the doctor's office staff for recommendations on a new doctor.
    - Write down questions before your visit, and don't be afraid to "bother" your doctor with those questions. If you have questions after leaving the doctor's office, call.
    - Before you have a test, ask the doctor to explain why it's important, whether it's the only way to get the needed information, the benefits and risks, and what it will cost.
    - If you're diagnosed with a medical condition and your doctor suggests a treatment, find out what it will or will not do, how much it will cost, and whether other treatments are available that would have the same results.
    - If your doctor suggests that you have surgery, get a second opinion on the need for the operation and other possible ways to treat your condition. Check if your health insurance will pay for both the second opinion and the operation. If you decide to have the operation, ask what your surgeon's fee is and what it covers, including whether it covers visits after the operation.[33] If the operation will be performed in a hospital, call the hospital beforehand to find out the related costs, such as anesthesia.

- If you're an employer, build a culture among your employees that promotes education about health care and health care consumption.

- Think about your prescription drug choices, and talk to your doctor and pharmacist. In general, the average price of brand name drugs is about three times the price of generic drugs. The Bureau of Elder and Adult Services has a website (www.state.me.us/dhs/beas/drugs/drug_survey.htm) that lists the prices across the state for 15 commonly used prescription drugs . You can use the "drug pricing calculator" on the site to determine the total price for the prescriptions you use. You can also ask your doctor about the cost of the drug he or she is prescribing, and about lower cost drugs you could try instead.

- If your health plan has a nurse hotline, and you get sick at night or on a weekend but are not sure if you need to go to the emergency room, call the nurse hotline for help.

- Talk to providers, including members of hospital boards, about their costs and need for the newest technology.

- Stop smoking. The Partnership for a Tobacco–Free Maine runs the Maine Tobacco HelpLine, which offers free and confidential telephone counseling to anyone who wants to stop using tobacco. The HelpLine number is 1-800-207-1230. You can also visit their website at: www.tobaccofreemaine.org/default.asp.

- Live a healthier lifestyle. The federal Agency for Healthcare Research and Quality can give you some ideas on taking charge of your health. Their guides include:

    - *Personal Health Guide: Put Prevention into Practice*, which will help you make sure that you get the tests, immunizations (shots), and guidance you need to stay healthy[34]
    - *Child Health Guide: Put Prevention into Practice*, which will help you become an active member of your child's health care team[35]
    - Staying Healthy at 50+: Put Prevention into *Practice,* which gives information on living habits that have been proven to help prevent certain diseases and conditions[36]

    The above listed guides are free from the Agency's website: www.ahrq.gov – or Publications Clearinghouse – 800-358-9295.

- If you're an employer, start or encourage your employees to participate in wellness programs promoting smart eating choices, exercise, or smoking cessation.

For more information...

The Maine Bureau of Insurance has many publications available to help consumers and small business owners. These can be requested from the Bureau by calling 1-800-300-5000 or can be downloaded from the Bureau's web site at: www.MaineInsuranceReg.org.

- *Health Insurance Complaint Ratios - 2000*
- *Consumer's Guide to Health Insurers Doing Business in Maine (Internet brochure)*

- *A Consumer's Guide to Individual Health Insurance*
- *What Can I Do If I Lose My Group Health Insurance?*
- *What Maine Small Employers Should Know About Health Insurance*

Many state and national data sources were used in compiling this brochure. If you'd like more information, the following may be particularly helpful:

www.healthweb.state.me.us – a website developed by the Maine Health Data Organization — includes information on how much was charged for various medical procedures in hospitals.

The Cost of Health Care in Maine: *Report of the Year 2000 Blue Ribbon Commission on Health Care,* www.mdf.org (under "Publications Available")

The Henry J. Kaiser Family Foundation State Health Facts Online, www.statehealthfacts.kff.org

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, www.ahrq.gov

Footnotes

[1] The Segal Company. 2002 Segal Health Plan Cost Trend Survey. October 2001.

[2] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 1999 Medical Expenditure Panel Survey – Insurance Component. Reported in: The Henry J. Kaiser Family Foundation. State Health Facts Online. www.statehealthfacts.kff.org.

[3] "Health insurance costs set to soar/U.S. health care costs/Why health insurance costs are rising," Omaha World – Herald. November 4, 2001.

[4] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys. Reported in: The Henry J. Kaiser Family Foundation. State Health Facts Online. www.statehealthfacts.kff.org.

[5] Healthcare Leadership Council. HLC Small Business Health Insurance Survey. Survey of 500 employers with 150 or fewer employees conducted June 27-July 13, 2000 by American Viewpoint, Inc.

[6] Data from the 2001 Cost Management Group Annual Compensation and Benefits Survey. Reported in: "Health plans top list of employee fringe benefits, with PPO and POS plans finding favor," Cost Management Update. October 1, 2001.

[7] Perrault, Michael. "Hewitt Associates study predicts employer health costs will rise 13% to 16% in 2002," Denver Rocky Mountain News. October 30, 2001.

[8] Market Decisions. Citizen Perceptions of Health Care Issues. July 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[9] Year 2000 Blue Ribbon Commission on Health Care. The Cost of Health Care in Maine: An Analysis of Health Care Costs, Factors that Contribute to Rising Costs, and Some Potential Approaches to Stabilize Costs. Report to Governor Angus S. King, Jr. November 2000.

[10] Maine Bureau of Insurance. Expenditure Composition for Domestic HMOs 2000.

[11] Willard, John. "Views from the top: The Maine 100," Portland Monthly Magazine. October 2001.

[12] Strunk, Bradley C., Ginsburg, Paul B., Gabel, Jon R. "Tracking health care costs: Hospital care surpasses drugs as key cost driver," Health Affairs (Web Exclusive). Data Bulletin No. 21, September 26, 2001. www.healthaffairs.org.

[13] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[14] Strunk, Ginsburg, Gabel (See note 12).

[15] Greene, Jay. "Surging demand for specialists spurs salary hikes: Practices and groups are having to pay, as well as deliver higher perks," AMNews. October 22-29, 2001 (based on data by Merritt, Hawkins & Associates 2001 Recruiting Incentive Study).

[16] Maine Hospital Association. Maine's Healthcare Workforce: Examining the Implications of a Growing Labor Shortage on Access to Hospital Care. September 2001.

[17] American Hospital Association data reported in: Wiebe, Christine. "Pharmacist shortage reflects profession's struggles," Medscape Money & Medicine. 2001.

[18] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists (Report to Congress). December 2000.

[19] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[20] Strunk, Ginsburg, Gabel (See note 12).

[21] The Segal Company (See note 1).

[22] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[23] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[24] Critical Insights. Attitudes Toward Administrative Inefficiencies in Health Care. 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[25] Urban Institute and Kaiser Commission on Medicaid and the Uninsured (See note 4).

[26] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[27] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death. December 1999. Reported in: The Henry J. Kaiser Family Foundation, State Health Facts Online. www.statehealthfacts.kff.org.

[28] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. CDC's Tobacco Info – State & National Tobacco Control Highlights – Maine. www.cdc.gov/tobacco/statehi/htmltext/me_sh.htm.

[29] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (See note 27).

[30] Maine Turning Point. "Survey shows Mainers willing to pay for better health" (press release). May 8, 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[31] Maine Bureau of Insurance. Results for HMO Business & Blue Cross Business in Maine, 1997-9/30/01.

[32] Maine Bureau of Insurance. A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature: Review and Evaluation of LD 403, An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons. May 9, 2001.

[33] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Be Informed: Questions to Ask your Doctor Before You Have Surgery. Pub. No. 95-0027. January 1995. www.ahrq.gov/consumer/surgery.htm.

[34] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Personal Health Guide: Put Prevention into Practice. Pub. No. APPIP 98-0027. Consumer Information, April 1998. www.ahrq.gov/ppip/ppadult.htm.

[35] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Child Health Guide: Put Prevention into Practice. Pub. No. APPIP 98-0026. www.ahrq.gov/ppip/ppchild.htm.

[36] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Staying Healthy at 50+: Put Prevention into Practice. Pub. No. 00-0002. January 2000. www.ahrq.gov/ppip/50plus/index.html.

Maine Bureau of Insurance's Consumer Assistance Hotline can help with questions and with problems with insurance companies.

Call 1-800-300-5000 or visit www.MaineInsuranceReg.org for help.

The Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates the insurance industry for solvency and consumer protection. It does so through its examining and licensing procedures of insurance companies, by licensing producers, by reviewing rates and coverage forms, by conducting audits, and by sponsoring programs that enhance awareness of and compliance with State laws. The Bureau has statutory authority to enforce the State's laws and rules pertaining to insurance, and it initiates investigations and holds hearings concerning possible infractions of them.

Alessandro A. Iuppa
Superintendent

Printed under Appropriation Number 014 02A 3041 012
January 2002

Tab #4

Maine's Mandated Benefit Review and Evaluation Law

(24-A ME. REV. STAT. ANN. § 2752)

MAINE REVISED STATUTES
Title 24-A, MAINE INSURANCE CODE
CHAPTER 33. HEALTH INSURANCE CONTRACTS

§ 2752. Mandated health legislation procedures

1**. Mandated health benefits proposals.** For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

2. Procedures before legislative committees. Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the Bureau of Insurance for review and evaluation pursuant to subsection 3. Once a review and evaluation has been completed, the committee shall review the findings of the bureau. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

3. Review and evaluation. Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

(1) The extent to which the treatment or service is utilized by a significant portion of the population;

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

(4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered;

(15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(16) The impact of making the benefit applicable to the state employee health insurance program;

B. The financial impact of mandating the benefit, including:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

(6) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(9) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(10) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State;

C. The medical efficacy of mandating the benefit, including:

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of practitioners:

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(b) The methods of the appropriate professional organization that assure clinical proficiency; and

D. The effects of balancing the social, economic and medical efficacy considerations, including:

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

Tab #5

Veto Message of Governor Angus S. King, Jr.

L.D. 1627, "An Act to Ensure Equality in Mental Health Coverage"

April 11, 2002

To the Honorable Members of the 120th Legislature:

Enclosed please find H.P. 1205, L.D. 1627, "An Act to Ensure Equality in Mental Health Coverage," which I am returning without my signature or approval.

In 1995, I signed a progressive mental health parity law that required health insurance coverage for 7 specific biologically based mental illnesses in policies held by employer groups of 20 or more. This new bill goes considerably beyond the 1995 act to expand mandated coverage to 11 categories of mental illness as defined in the Diagnostic & Statistical Manual of Mental Disorders (increasing the number of potentially covered disorders to over 40); to include licensed clinical professional counselors in the definition of providers eligible to treat mental illness and receive reimbursement for those services; and to require coverage for residential treatment services and home support services. The addition of anxiety disorders, personality disorders, attention-deficit/disruptive behavior disorders and the substance abuse aspects of those illnesses already covered under the 1995 law inevitably will increase health insurance costs.

While the bill before me is well intentioned, it is offered in a period of dramatically escalating health care and insurance costs. As we look for ways to reduce the costs of health care, we must not exacerbate the problem by adding new mandates. When you are in a hole, the first rule is not to dig any deeper. This bill would serve to make the hole deeper, because the addition of another mandated benefit virtually guarantees that the cost of health insurance for employer groups of 20 or more will increase. I realize that cost estimates in connection with this bill are in the range of .5% of current premiums; but in the current climate, <u>any</u> increase mandated by the state is unacceptable, particularly in an area where significant growth can be expected.

We already know that more and more employers are being presented with increases in health insurance renewal premiums that range from 25% to 50% and more. According to one national estimate, the health insurance cost for each employee will increase an average of $746 this year. During the first session of the 120th Legislature, we heard testimony about specific businesses and their premium increases. For example, a retail tire business with 31 employees saw its health insurance rates increase over 42% from 1998-2000, and a physician practice with 32 employees saw its rates increase over 20% from 1999 to 2001. These and other Maine businesses are forced to confront difficult choices: do they continue existing policies at a significant increase in cost and shift more of the cost of the health insurance to employees; do they retain coverage but offer higher deductible policies; do they forego increasing employee salaries to maintain coverage; or do they drop coverage altogether? All of these options translate into less money in the pockets of Maine citizens.

Proposals to try to make health insurance more affordable, such as those brought forward by Speaker Saxl and President Bennett, have dominated this Legislative session. It is worthy of note that L.D. 1627 will have exactly the opposite effect and will serve to make

health insurance more expensive. The bill itself recognizes this fact, by including an appropriation to the general fund to cover the increased costs to the state employee health plan. Many other Maine employers that provide health insurance will have to do the same thing if L.D. 1627 takes effect.

The bill also anticipates savings to the general fund, reflected in a deappropriation of funding for the Departments of Behavioral and Developmental Services and Human Services. These deappropriations are predicated upon expected savings to state programs to be gained by shifting these costs to employers and employees in the private insurance market. I am reluctant, however, to accept these "anticipated savings" because is not clear to what extent employers or employees are likely to drop coverage due to increasing health insurance premiums.

We are facing a health insurance crisis in this state, and accordingly, it is a particularly bad time to add costs, regardless of how big or small. As we face expected double-digit increases in health insurance costs for at least several more years, we cannot ask people who can barely afford what they have now to pay more. While expanding mental health care is a worthy goal, we cannot allow the best (comprehensive coverage including full mental health benefits) to become the enemy of the good (any coverage at all).

Because of the objections outlined above, I am in firm opposition to L.D. 1627 and I respectfully urge you to sustain my veto.

Sincerely,
S/Angus S. King, Jr.
Governor

Tab # 6

Maine Health Care Performance Council

The Maine Health Care Performance Council envisions that all Maine citizens will participate in a health care system that is integrated, affordable, accountable and accessible.

Goal Statements

The health care system should be structured to promote appropriate participation by consumers, providers and payers.

The health care system should be cost-effective and financed to ensure its long-term sustainability.

The health care system should produce quality outcomes and information to improve the health of Maine citizens.

Subgoals

Physical Participation
Does the system promote appropriate participation by consumers and providers?

Financial Participation
Does the system's payment system support the vision?

Other Issues
Are there issues related to culture, disability or education that inhibit access?

Distribution of Payer Cost
Who pays and how much? Who doesn't pay? Where do the dollars go?

Provider Costs
How much does it cost to deliver the services being bought?

Unit and Utilization Costs
What is the service delivery cost per unit? How is it related to utilization?

Other Cost Areas
What are cost implications of public health? What are cost drivers in the system?

Cost Shifting
Where/who are costs being shifted from? And where/who are costs being shifted to?

Structural Quality
Does the system's infrastructure support the collection, analysis and dissemination of information to its users?

Treatment Quality
Does the infrastructure promote and support the provision of quality treatment?

Quality of Outcomes
What are the health care results of interventions, and how does the system affect them?

Tab # 7

Additional Resources

Additional Resources

Characteristics of Maine's Health Insurance Market (Tab 2):

White Paper: Maine's Individual Health Insurance Market (January 2001):

http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.htm (HTML)
http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.doc (MS Word)
http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.pdf (Adobe PDF)

"The Cost of Health Care in Maine," Report of the Year 2000 Blue Ribbon Commission on Health Care (November 2000):

http://mdf.org/chc/

LD 1627, "An Act to Ensure Equality in Mental Health Coverage" (Tab 5):

Review and Evaluation of LD 1627, An Act to Ensure Equality in Mental Health Coverage:

http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.htm (HTML)
http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.doc (Word)
http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.pdf (Adobe PDF)

Maine Health Care Performance Council (Tab 6):

http://www.mdf.org/mhcpc